

**THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH**

**REPORT**

**ON**

**THE HEALTH BENEFITS PLAN  
MEMBERS' BILL OF RIGHTS LAW**

**JANUARY 14, 2000 - SEPTEMBER 20, 2001**

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## **EXECUTIVE SUMMARY**

### **I. INTRODUCTION**

The Health Benefits Plan Members' Bill of Rights Law gave District of Columbia residents many new and important consumer rights in the field of health care. Among the most significant is the right to appeal to an independent organization when a health maintenance organization (HMO) or other managed care plan denies, limits or terminates a covered service on the grounds that it is not medically necessary. The right of appeal is administered by the District of Columbia's Department of Health (Department).

This is the first annual report to the District of Columbia Council on the results of the external appeals process. The report covers a nine (9) month period from January 14, 2000, when the District of Columbia rules became effective as to health care plans through September 30, 2000, and its second year of operation January 1, 2001 through September 30, 2001.

As expected, appeals filed during the period January 14, 2000 through September 30, 2000, were nominal. All appeals filed were reviewed and rejected except one. From January 1, 2001 through September 30, 2001, the number of appeals was small when comparing it to the estimated 192,000 District of Columbia residents covered by managed care plans. But this is consistent with the number of appeals in states with comparable programs in terms of volume. Most states report a low volume of appeals in the first year of their programs. While their figures were somewhat higher than the District's, their volume was low compared to the residents covered by managed care plans.

It is important to remember that members are required to exhaust their plan's internal appeal process before applying for an appeal to the independent review organization. Under District of Columbia law, insurers must have an internal appeals process that meets certain standards set by the law and rules. This system was established in this way as an incentive for HMO's and other managed care plans to resolve most disputes internally, with only unresolved issues reaching the external appeal stage. We expect the number of appeals to increase in the coming year, mainly because of the extensive media campaign being planned by the Department of Health.

The law also requires that members with chronic disabling or life threatening conditions choose a health care specialist as the member's primary care provider. The member can receive medically necessary or appropriate specialty care for more than one visit without having to obtain the Health Benefits Plan approval. In addition, Health Benefits Plan female members may designate as their primary care provider a participating physician or advance practice registered nurse who specializes in obstetrics and gynecology.

## **II. OVERVIEW OF THE PROCESS**

Every Health Benefits Plan Member has the right to appeal a decision by the Health Benefits Plan that results in a denial, reduction, limitation, termination, or delay in covered health care services. Under the District of Columbia law and regulations, each Health Benefits Plan is required to provide members with the opportunity to resolve an appeal through a two-stage internal appeal grievance process. If a member is dissatisfied with the results of the Health Benefits Plan's internal grievance process, the law provides the member with the right to an external appeal by an Independent Review Organization (IRO). There is no cost to file an appeal.

The law requires that the Health Benefits Plan's member handbook contain an explanation of the internal appeals process. The Plan is also required at each stage of the internal grievance process to advise the member about the next level of appeal. Appeals can be filed either by the member or by the member's representative acting on behalf of a member with the member's consent.

At the first stage of the grievance process, the individual filing the grievance will have the opportunity to discuss the grievance with the medical director and/or the physician or health care provider designee who rendered the decision. If the grievance is not resolved satisfactorily, it can be pursued to the second stage. At the second stage, the health benefits plan will select a panel of physicians, advanced practice registered nurses, or other health care professionals who have not been involved in the case to review the grievance. The panel can be composed of health care professionals who are part of the health benefits plan's network, or outside consultants in the appropriate specialty. If the health benefit plan maintains its denial at the conclusion of this stage, it must provide the individual with written notification and reasons for the denial, as well as instructions on how to file an external appeal, along with the appropriate forms.

To file an external appeal, the health benefits plan member, or a representative, must submit a letter, or an appeal application with appropriate documents, to the Department of Health, Office of the General Counsel, Grievance and Appeals Coordinator, within 30 business days of receipt of the health benefit plan's denial. The Director of the Department of Health (Director) will review the letter or application with documents to ensure compliance with the law and regulations. The letter with documents is then forwarded to an Independent Review Organization. The Independent Review Organization will conduct a full review of the case. If the Independent Review Organization determines that the member was deprived of medically necessary covered services, it will recommend to the Director the appropriate covered health care services the member should receive. The Director shall forward copies of the recommendation to the member, member representative, and the Health Benefits Plan. The Health Benefits Plan in return is required to notify each of the parties whether it will accept the

Independent Review Organization's recommendations. If not, it must explain in detail the reason for the rejection. The insurers subject to the Health Benefits Plan Members' Bill of Rights law are those subject to state regulations and do not include Medicare, Medicaid, the Federal Employees Health Benefits Plan, or the federally regulated self-funded plans.

### **III. OVERVIEW OF INDEPENDENT REVIEW ORGANIZATION CERTIFICATION**

All external appeals, during the periods covered by this report, have been conducted by one of the following independent review organizations: (1) Delmarva Foundation, Inc., Easton Maryland; (2) Hayes Plus, Inc., Lansdale, Pennsylvania; or (3) Island Peer Review Organization (IPRO), Lake Success, New York. These organizations have been certified by the Department of Health as independent review organizations and each is under contract to the Department as required by the law and the regulations. The independent review organizations, which consist of medical professionals including physicians whose specialty covers the area under review, examines cases on the bases of medical records and other materials, generally accepted practice guidelines and applicable clinical protocols. If the member requests a hearing, the independent review organization must hold a hearing within the District of Columbia. Members pay no fees for an appeal. If the member is represented by an attorney, the member must pay the attorney fees. Members are given up to thirty (30) days from the date of the denial by the Health Benefits Plan to file an appeal. Under normal circumstances, a decision must be rendered by the independent review organization within thirty (30) days after receiving all documents, but the independent review organization can act within hours, if necessary. Emergency appeals must be reviewed within 72 hours.

The Director is required to apply and enforce certification standards when certifying the three (3) independent review organizations. These standards are to ensure that an independent review organization: (1) properly maintains a policy involving the review of the appeal in strict confidence; (2) uses only qualified professionals and medical reviewers; and (3) demonstrates an ability to render decisions in an equitable and timely manner.

The independent review organization may not be a subsidiary or in any way owned or controlled by a health benefits plan, insurer, or trade associations of health care providers. The independent review organization also should not have any material professional, familial, or financial conflict of interest with the following: (1) the insurer; (2) any officer, director, or management employee of the insurer; (3) the physician, the physician's medical group or the independent practice associates or the treating provider proposing the service or treatment; (4) the institution at which the service or treatment should be provided; (5) or the development or manufacture of the principal drug, device, procedure, or other therapy proposed for the member whose treatment is under review.

The independent review organization must have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials. Finally, neither the independent review organization nor an individual working for an external review panel can be held liable for any recommendation presented by the independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct. The Director assigns appeals to one of the certified independent review organizations on a random basis. The Director may deny any assignment to any independent review organization if it is determined that making an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety.

#### **IV. STAFFING**

To carry out the new regulatory responsibilities under the law and regulations, the Director established the position of Grievance and Appeals Coordinator within the Office of the General Counsel. As the volume of external appeals increases, it is anticipated that the following positions will be established: (1) an administrative assistant and (2) an insurance examiner (Health). These personnel will be expected to perform the administrative and technical work required by the law and regulations. Personnel are expected to be available on weekends and holidays to handle expedited appeals.

#### **V. COST OF IMPLEMENTING THE LAW**

Pursuant to the law, the Health Benefit Plans are required to fund the implementation of the law. Section 109 of the law specifically provides that the Mayor shall assess all insurers to cover all the costs of administering this act. The Mayor shall promulgate regulations to determine the assessment formula. The assessment formula as promulgated in the regulations provides that the assessment payable by each insurer shall be calculated by taking the total cost of the program multiplied by the percentage of non-Medicare or non-Medicaid gross direct premiums written in the District of Columbia attributable to that insurer in the prior calendar year, provided that each insurer shall be subject to a minimum annual assessment of no less than \$100. Payment shall be made by the insurer within ten (10) days of receipt of the assessment notice. The monies collected from each insurer subject to the assessment is placed in the general fund in a dedicated account to pay the costs and expenses incurred by the Department of Health related to the implementation and administration of the law.

The assessment of insurers is performed by the Department of Insurance and Securities Regulation under a Memorandum of Agreement with the Department of Health. There was no assessment of insurers for the fiscal year 2000. The first statutory assessment was conducted for FY 2001. The total of invoices for FY2001 was \$438,530.

## **VI. FINDINGS AND CONCLUSIONS**

Information relating to the number and type of external appeals filed with the Office of the General Counsel (Office) is set forth in the Appendix.

During FY 2000, the Office received a total of twelve (12) requests for external appeal. Of the number of requests received one (1) was forwarded to an Independent Review Organization, two (2) were withdrawn, and nine (9) were rejected. There were approximately seven hundred and fifty (750) requests for assistance.

During FY 2001, the Office received a total of thirty (30) requests for external appeal. Of that number nine (9) requests were forwarded to an Independent Review Organization, one (1) was withdrawn, ten (10) were rejected and ten (10) requests were closed administratively. There were approximately twelve hundred (1,200) requests for assistance from members. In 2001, it is estimated that \$31,162 in benefits were paid to members who exhausted the external appeals process. It is also estimated that \$19,000, was not paid in benefits due to the Insurer's non-acceptance of the Independent Review Organization's recommendations.

We have learned that if this program is to be successful, consumer outreach is imperative. After receiving numerous telephone inquiries for assistance, we realized that members are often confused about their external review eligibility. Also, most of the studies done in this area show that the low volume of appeals was due to the lack of consumer awareness and the burden of illness, which may prevent consumers from pursuing external appeals. Moreover, in states where consumer outreach increased, the number of appeals increased significantly. In an effort to increase consumer outreach, District of Columbia law requires that members who receive an adverse decision from the insurer be given their appeal rights along with instructions on how to appeal. The law also requires insurance plans to include such information in their members' handbooks.

Through available funding, the Office has appropriated \$50,000 for advertising. In 2002, the Office will conduct quarterly media campaigns to inform D.C. citizens about the program. In the past we have taken every opportunity to publicize the program. Thus far, the Office has appeared at community meetings, legal seminars, and health programs sponsored by non-profit corporations; developed brochures with specific appeal instructions for distribution to the public; and developed a web site that provides information about the program, including the appeal form and the authorization for the release of medical records.

**VII. RECOMMENDATIONS**  
**(Section 107 (P) (D.C. Code 32-571 (P))**

Amend the law to make the decisions for the independent review organizations binding on the parties, or at a minimum binding on the insurer.

Clarify the law to make it clear that the Department of Health is responsible for external appeals involving medical necessity. All other complaints involving non-medical necessity issues should be the responsibility of the Department of Insurance and Securities Regulations.

A definition of medical necessity should be included in the law.